CITY OF GAHANNA
DEPARTMENT OF PARKS & RECREATION

Internal Use Only
- ☐ Spring Break
- ☐ Camp Friendship
- ☐ CORE

Camp Health History Form 2013

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form must be provided to camp staff upon participant's arrival at camp. PLEASE provide complete and current information so that the staff can be aware of your camper's needs.

Camper Name_____ Birth Date_____ Age_____
Last First Middle

Home Address_____
Street City State Zip

Custodial Parent/Guardian_____ Phone_____

Home Address_____
(if different from above) Street City State Zip

Business Address _____ Phone_____
Street City

Second Parent/Guardian/Emergency Contact_____ Phone_____

Home Address_____
(if different from above) Street City State Zip

Business Address _____ Phone_____
Street City

If not available in an emergency, notify_____

Relationship_____ Phone_____

Home Address_____
Street City State Zip

Insurance Information
Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name_____ Group #_____
*** Photocopy of front and back of health insurance card must be attached to this form.**

Parent/Guardian Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to camp staff to provide routine health care, administer prescribed medications, and seek emergency medical treatment including x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to camp staff to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by camp staff to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of Parent/Guardian _____

Printed Name_____ Date_____

I understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of Minor _____ Date_____

For religious or other reasons I chose not to sign this, and do not authorize treatment for the participant listed above.

Signature of Parent/Guardian or Adult Staffer_____

Printed Name_____ Date_____

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Camper Name_____ Birth Date_____
Last First Middle

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry ☐ Seafood ☐ Eggs ☐Wheat/Gluten ☐ Other (Please Describe)_____

Explain any restrictions to activity (what cannot be done, what adaptations or limitations are necessary):

_____

_____

ALLERGIES ☐ This person **has NO known allergies** OR ☐ This person **has the following allergies**

☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc) ☐ Other_____

Please describe specifically what the participant is allergic to and the reaction seen: _____

_____

SUNCREEN ☐ **I give permission to camp staff to apply sunscreen to my child**

OR

☐ **I give permission for my child to apply and be responsible for their own sunscreen application**

SWIMMING ABILITY ☐ Can't swim ☐ Beginner ☐ Intermediate ☐ Advanced

GENERAL QUESTIONS (Explain "yes" answers below)

Has/does the participant:	Y	N
1. Had any recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints?	☐	☐
18. Have an orthodontic appliance at camp?	☐	☐
19. Have any skin problems (itching, rash, etc)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/constipation?	☐	☐
24. If female, have an abnormal menstrual history?	☐	☐
25. Ever had an eating disorder?	☐	☐
26. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the questions. _____

_____

_____

_____

_____

WHICH OF THE FOLLOWING HAS THE PARTICIPANT HAD?

☐ Measles ☐ Chicken Pox ☐ German Measles ☐ Mumps ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which camp staff should be aware: _____

_____

_____

_____

Name of family physician_____ Phone_____

Address_____

Name of family dentist/orthodontist_____ Phone_____

Address_____

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Camper Name_____ Birth Date_____
Last First Middle

IMMUNIZATION HISTORY: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis (DTaP) or (TdaP)						
Tetanus booster (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal(PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						

0

Tuberculosis (TB) test	Date:	□ Negative □ Positive

MEDICATIONS BEING TAKEN
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Keep medications in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

□ This person **takes NO medications** on a routine basis OR □ This person **takes medications** as follows:

Med #1_____ Dosage_____ What Time?_____

Reason for taking_____

Med #2_____ Dosage_____ What Time?_____

Reason for taking_____

Attach additional pages for more medications.
Please identify any medications taken during the school year that participant does/may not take during summer:

_____

_____

For staff use:

Staff review _____ Date _____ Time _____ Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____ Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____ Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____ Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____ Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____ Staff review _____ Date _____ Time _____
Staff review _____ Date _____ Time _____ Staff review _____ Date _____ Time _____

Medications received_____

Any needs identified_____

Updates/additions to health history □ Yes □ No □ None required

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Camper Name_____ Birth Date_____
Last First Middle

Authorization for Child Pick-Up

I give permission to any person named on this document as a parent, guardian, second parent, second guardian, or emergency contact to pick up this participant from camp. I understand that I and any authorized persons must show appropriate photo identification to remove this participant from camp at any time.

ADDITIONAL AUTHORIZED PERSONS (Must be 18 years of age or older):

Name_____

Relationship_____Phone_____

Name_____

Relationship_____Phone_____

Name_____

Relationship_____Phone_____

Name_____

Relationship_____Phone_____

Name_____

Relationship_____Phone_____

☐ I authorize the above additional authorized persons to pick-up this participant from camp.

☐ I do NOT authorize any additional people to pick-up this participant from camp. Only those people named on this document as a parent, guardian, second parent, second guardian, or emergency contact to pick up this participant from camp.

Signature of Parent/Guardian_____

Printed Name_____**Date**_____